

TWO YEAR REVIEW OF THE USAID/NEPAL HIV/AIDS STRATEGY 2001-2006

Submitted by:

**Billy Pick, ANE/TS
John Rogosch, GH/HIDN/MCH
Cathy Thompson, GH/RSC
Cameron Wolf, GH/OHA**

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TWO YEAR REVIEW OF THE NEPAL HIV/AIDS STRATEGY MARCH 2004

I. Background

Two-Year Review

The USAID/Nepal HIV/AIDS strategy was developed with the assistance of a team from USAID/Washington, in December 2000 and approved by the Office of HIV/AIDS in June 2001. Nepal is a USAID HIV/AIDS intensive focus country due to its concentrated epidemic. Nepal was the first country to have an approved strategy and is the first country to have a strategy review after two years of implementation. The Office of HIV/AIDS requires that strategies be reviewed after two years to assess the achievements of Intermediate and Sub-intermediate results and determine if any mid-course corrections are needed to ensure achievement of the strategy goals. The strategy review team included; Billy Pick, ANE HIV/AIDS Technical Advisor, Cameron Wolf, GH/OHA, Cathy Thompson, GH/RCS and John Rogosch, GH/HIDN, along with the USAID/Nepal HPN SO Team Leader, Sheila Lutjens and the USAID/Nepal HIV/AIDS team of Jesse Brandt, Nadia Carvalho, Shanta Gurung, Pangday Yonzon, Hari Koirala and Anne Peniston. The USAID/Washington team prepared this discussion paper.

The attached schedule outlines the meetings and field trips conducted by the team with the MOH, NCASC, implementing partners and field trips. Due to a Maoists planned “Retaliation Day” the team was not able to get out of the valley to visit others areas of Nepal. Also attached is the SOW for the review team from Washington.

Nepali Context

Nepal is a landlocked country of 23 million people sharing borders with India and China. The Himalayas cover the northern third of the country from east to west, bordering China. To their south lies a long east-west stretch of lower mountains (the hilly region) whose southern flanks flatten into the Terai, a fertile, sub-tropical plain spanning the border with India. These contours have played a major role in helping to determine the geographical and social diversity that characterizes Nepal. Administratively, Nepal has 75 districts divided into five development regions (Far-Western, Mid-Western, Western, Central and Eastern).

In the Human Development Report 2001, Nepal features among the economically poorest countries in the world. Nepal’s social indicators remain well below the average for the South Asia region: more than 40% of the Nepali population lives below the national poverty line; nearly half of all children below 5 years are underweight; and nearly 60% of all adults are unable to read or write. Additionally, women have traditionally a lower status than men, and gender inequality is deeply rooted. More boys than girls receive any form of education, women generally work longer hours than men and men have better access to services, including health.

Status of the Epidemic 2002 and 2004

The HIV epidemic has not changed significantly in the past two years. The country is still in a concentrated epidemic with the risk of a rapid increase within most-at-risk groups, followed by spread to the general population via “bridge populations”. Without effective interventions, WHO predicts that AIDS will become the leading cause of death in the age group of 15-49 year olds

over the next 10 years. The data collected from the Family Health International (FHI) Behavior Surveillance and Sero Prevalence surveys (BSS) in 2001 and 2002 are still the most recent information for IDUs, FSWs in Kathmandu valley and returned migrants from India in Achham and Doti districts.

The recent data from the Nepal Red Cross blood collection and the FSWs in the Terai eastern 16 districts show that the epidemic has not yet spread to the general population. The 2003 Terai FSW BSS found a 3% prevalence of HIV compared to 3.9% in 1999. There are 1,343 Nepal Red Cross blood collection sites in 40 districts that collected more than 73,000 pints of blood between June 2002 and May 2003 and reported an HIV prevalence of 0.44%. This is consistent with the data from 2000. Sero-prevalence studies of the MSM population have not been conducted.

In 2003 adult HIV cases for Nepal were estimated using all available data from surveys conducted in Kathmandu Valley, Highway districts, far-western districts and the remaining Hill districts. In total 60,000 adult HIV cases were estimated for 2003 in Nepal. 26% of the cases were women, 40% were returned migrants, 18% clients of sex workers and 14% injecting drug users. 15% represent women from rural areas of Nepal.

The Nepal Initiative

In September 2001, UNDP signed a 12-month agreement with FHI to implement an expanded rights-based response to the concentrated HIV/AIDS epidemic in Nepal. The program, initially one year, focused on FSW, clients and IDUs in Kathmandu valley. It was designed as an emergency response to the concentrated epidemic pending the finalization and resourcing of the National Strategy. The consortium of donors included DFID, AusAID, UNAIDS, UNDP and USAID. The USAID-funded FHI program served as the basis for this initiative. Relevant USAID program activities were viewed as a contribution to the Nepal Initiative.

The Nepal Initiative reached the IDU target population working with 20 NGOs to conduct peer education, establish drop in centers and provide needle exchange programs for the IDU networks in Kathmandu valley, Pokhara, Dharan and along the highways. This vital activity was curtailed in December 2002 when the MOH decided to stop funding the FHI supported NGO, the Center for Harm Reduction and take on the responsibility through the National Center for AIDS and STD Control. Eventually, the NCASC contracted with Save the Children/US to implement the program. By March 2004 the number of NGOs funded to reach the IDU population decreased to 10 and the current funding expires in April 2004. The National Strategy is still not resourced. The Nepal Initiative is completed and the donors are still waiting for the Government of Nepal to operationalize the national strategy before committing funds.

II. Summary of the Strategy

The USAID Strategy was developed in Nepal in 2001 to address the issues of a concentrated epidemic with the goal to maintain Nepal's low national prevalence below 1% of the population. HIV/AIDS activities fall under USAID/Nepal's Strategic Objective 2 "Reduced fertility and protected health of Nepalese families" and Intermediate Result (IR) 2.3, *Increased use of HIV/STI prevention and care services by most-at-risk groups (i.e. FSW and clients, IDU, MSM, migrant males).*

Under this strategy there are three sub-IRs:

- Sub-IR 2.3.1: Increased national capacity to provide HIV/AIDS services
- Sub-IR 2.3.2: Increased access to information and prevention services for HIV/AIDS and other sexually transmitted infections
- Sub-IR 2.3.3: Increased access to care and support

The strategy presented program capabilities and recognized the importance of the cross cutting issues of youth in high-risk groups, gender, involvement of people living with HIV/AIDS (PLWA), tuberculosis (TB) linkages, human rights and stigma, non-governmental organization (NGO) capacity building, and the regional linkages in South Asia.

The USAID strategy covers a wide geographic area, which aims at reaching the most-at-risk populations. Sub IR 2.3.1 will be working at the national level with HMG/N and the Ministry of Health (MOH) as well as building NGO capacity for program implementation. Sub IR2.3.2 will work in the 22 border districts with India (including urban areas), the three municipalities in the Kathmandu valley, the cities of Pokara and Dharan in the middle and eastern regions and in at least three Far Western hill districts where the main Mumbai migration occurs. Sub IR 2.3.3 will concentrate initially in the urban centers but expand to reach the five regional centers and hilly areas with the highest migration to Mumbai.

Review of Assumptions Presented in the Strategy

Government stability and priority to HIV:

In recent years, HMG/N has been de-stabilized by increasing strikes, violence and disruptions from a political movement known as the Maoists. In early December 2001, however, the government declared a state of emergency in which the Maoists were declared illegal, and a crackdown of their activities through intensive military involvement began. While the conflict is increasing, many local NGOs were still able to work in the Maoist-affected areas. The Nepal Red Cross Society reported the Maoists provided assistance to get needed services to the population. USAID decided to build on these NGO networks to continue the HIV/AIDS program.

However, in this environment of political instability, HIV/AIDS may lose its priority by the government, and disruptions may threaten program implementation. This strategy assumed that the government will keep its HIV/AIDS priority and our NGO partners will still be able to get services to the population.

Donor commitment to Nepal:

USAID/Nepal took into consideration international donor priorities and programs in the strategy. The UN agencies, DFID and other donors committed to completely fund the National Strategy. The UN HIV/AIDS Theme group took the lead in donor coordination and USAID was a major partner in that process. USAID worked in close collaboration with these donors, and the USAID strategy was considered a portion of the total funding for the national strategy. USAID has confidence that the other donor priorities would continue. In the event that other donors changed their priorities and were unable to address the prevention and care needs of certain groups (i.e., IDUs), USAID would remain flexible to fill gaps and/or help to mobilize support from other agencies.

Indicators Proposed in the Strategy

Strategic Objective 2: Reduced Fertility and Protected Health of Nepalese Families

IR 2.3: Increased use of HIV/AIDS prevention and care services by the most-at-risk groups (FSW, IDU, MSM, migrant males)

- 2.3.0 Percent HIV positive among female sex workers (FSW)
- 2.3.1 Surveillance conducted according to international standards
- 2.3.2 AIDS Program Index
- 2.3.3 Number of USAID-assisted indigenous NGOs providing HIV/AIDS services
- 2.3.4 Measurement of stigma reduction – indicator to be determined
- 2.3.5 Condom use
 - a. Use at last risky sex
 - b. Consistent use
- 2.3.6 Total condom sales
- 2.3.7 Total condom sales to most-at-risk groups
- 2.3.8 Number of USAID-assisted sites providing sexually transmitted infection treatment
- 2.3.9 Number of most-at-risk individuals receiving sexually transmitted infection treatment
- 2.3.10 Percentage of men in most-at-risk male sub population groups who report sex with FSW in the last 12 months
- 2.3.11 Voluntary HIV counseling and testing sites established according to national standards
- 2.3.12 Number of clients seen at voluntary counseling and testing sites
- 2.3.13 Number of people living with HIV/AIDS reached with basic care and support services in USAID-targeted areas

III. Assessment of Progress by Intermediate Result

IR 2.3.1 Increased national capacity to provide HIV/AIDS services

Activity 1. Government leadership and management of the national HIV prevention and care response strengthened

In a challenging environment of regularly changing government leadership and lack of continuity in both the Ministry of Health and the National Center for AIDS and STI Control (NCASC) technical and managerial staff, there have been substantial achievements and progress in strengthening government capacity. The overall approach is to nurture and facilitate major contributions that have been made by USAID and its partner CAs.

Achievements:

- FHI provided support for the organization and technical guidance of five working groups in the NCASC, including those BCC/BCI, Surveillance, ART, VCT and STI, which have developed technical guidelines for the national program.
- In collaboration with other donors, USAID supported the NCASC in preparing the National HIV/AIDS Strategy, a one-year national Operational Plan, and a five-year Operational Plan. The National HIV/AIDS Strategy and one-year Operational Plan have been approved, while the five-year Plan is being finalized.
- FHI supported 36 HMG/N staff for exposure visits, conferences and training, and disseminated major research findings to guide program planning
- In early 2003, POLICY Project opened their office in the NCASC to provide the NCASC with technical assistance and to build its capacity as a leader in the HIV/AIDS program in Nepal. The selection of a Country Director who is a former senior, highly-respected government official has been an important factor in fostering access and input into strengthening NCASC policy and decision making. POLICY is currently moving from NCASC to outside offices that will permit it to expand its work with civil society, as well as maintain its work with the Center. In its first year, the POLICY team has strengthened information access and dissemination through creation of a web site and area network, established multi-sectoral partnerships which support sensitization, and organized a number of advocacy events.
- POLICY initiated development of an HIV/AIDS Strategy and HIV education curriculum for the police, and leadership/advocacy training for IDUs and FSWS so that they can advocate for HIV prevention services.
- The NCASC has received a initial funding from the GFATM to support the hiring of seven new long-term technical staff for the NCASC. USAID and its partners played an important role in developing the HIV/AIDS portion of the proposal which the GFATM awarded to HMG in 2003.

Challenges:

Although much has been achieved, as noted earlier, the major challenge in strengthening national level capacity is the lack of continuity in leadership and management in the NCASC and Ministry of Health, and limitations on implementation capability. It is expected that this will continue for the immediate, if not longer-term future. However, FHI, POLICY and PSI have coped with these changes to strengthen guidelines, working groups, planning and implementation mechanisms that support and are incorporated into the national program.

Recommendations:

The Mission and its key CA partners have adopted a useful opportunistic approach to strengthening government capacity, despite continual changes in NCASC and Ministry personnel. With the addition of planned new NCASC staff, the potential development of the Management Support Agency for the national plan, and further development of the GFATM-supported program, a number of new opportunities for involvement could emerge, to which USAID team should be prepared to respond. This could include, for example, orientation and training for new NCASC staff members to facilitate their rapid integration into the program.

Activity 2. Supportive policies to facilitate effective HIV prevention and care program implementation developed

The addition of the POLICY Project team and PSI, coupled with FHI's work, has greatly augmented capacity in the policy area, and a number of important outcomes have resulted or are in progress.

Achievements:

- The POLICY Project team conducted a study on the Greater Involvement of People with AIDS (GIPA) in Nepal, and has incorporated this theme into all of its efforts to strengthen NCASC policy, advocacy and legislation, and actively promoted active participation of PLWHA in key political discourse.
- POLICY conducted a Legislative Audit to assess Nepal's compliance with the International Guidelines on HIV/AIDS and Human Rights, which will soon be disseminated, and also supported a study of the media coverage of HIV/AIDS issues.
- As noted above, FHI's contribution to organizing technical working groups and technical guidelines has been an important factor in strengthening technical policy and program guidance in the NCASC.
- FHI is working with the planned development of a national HIV/AIDS BCC strategy and facilitated development of various national technical guidelines.

Challenges:

Continuing changes in leadership and the lack of a strong political commitment are an impeding force in the pursuit of an improved policy environment. But the achievements demonstrate that there are many possible avenues that the HIV/AIDS team partners are pursuing.

Recommendations:

These efforts can be further reinforced by coordinated planning of the specific components of the HIV/AIDS policy by the USAID partners.

As part of the overall program strategy and annual work plan/budget preparation, a unified policy agenda and/or workplan should be drafted, identifying the specific responsibility for component activities of each CA partner and any joint contributions /collaboration that may be needed. This HIV/AIDS program policy agenda could also be a useful tool for the Mission to be used as a reference by senior SO team staff, the Mission Director and the Ambassador and his team in their interactions with key Nepali leaders.

Activity 3. First and second generation surveillance systems to monitor HIV, STI and risk behaviors in the general population and with most-at-risk groups implemented

The Nepalese government usually conducts first generation sentinel surveillance at six STI clinic sites (with an additional three sites planned), which provide sero-prevalence data. However, for the last 2 years, sentinel surveillance at these 6+3 sites has not been conducted.

Achievements:

- Following the development of a Surveillance Technical Working group with the assistance of FHI, a surveillance plan for carrying out second generation surveillance surveys (BSS and sero-prevalence) was established in 2002. FHI completed size estimations, BSS and sero-prevalence studies among FSWs and IDUs in the Western and Eastern districts, and similar surveys among MSM in the Kathmandu Valley have begun. FHI worked with the National Research Council to carry out these studies.
- JICA supported procurement of rapid HIV test kits for sentinel surveillance and STI drugs.
- USAID included sentinel surveillance in the Red Book activities (NFY02-04) with the NCASC (reagent procurement) however sentinel surveillance was not conducted. The transportation and storage of procured reagents and drugs (USAID and JICA procured) has been added to the Supplemental Fund.

Challenges:

Because of low ANC coverage in Nepal, STI centers were originally selected to serve as HIV sentinel surveillance (HSS) centers, but they have not conducted surveillance activities for the past two years. In the absence of an organized HSS mechanism, these ad hoc surveys are serving as the only source of HIV prevalence data for Nepal.

Another issue is the paying of Rs. 100/- per blood sample to government laboratories to “cover” the cost of processing. This is not justified under any regulation and USAID did not agree to support this “tradition” through its supplemental funding arrangement with NCASC..

Recommendation:

The surveillance technical working group could consider using the Nepali Red Cross blood donation system for national sero-prevalence estimates.

There is a need for a policy level intervention to bring NCASC and the National Public Health Laboratory (NPHL) together to work for surveillance and VCT.

Activity 4. Laboratory capabilities for HIV and STI diagnosis for service delivery and surveillance strengthened

Achievements:

- USAID funded ICDDR,B to assess the capacity of 16 government and non-government laboratories to support HIV sentinel surveillance and VCT, and included the national reference laboratory, the National Public Health Laboratory. The results identified only a small number of laboratories that are currently of a quality which could be upgraded to acceptable standards with minimal inputs.

- FHI and ICDDR,B have initiated pilot activities to strengthen STI and AMR testing, providing both staff training and upgrading laboratory facilities.

Challenges:

The ICDDR,B study revealed broad weaknesses in much of the existing laboratory network which would require substantial investments to bring the facilities up to standard, assuming trained staff would be available. The study outlined what improvements are needed in each facility, so planned improvements would be dependent on donor resources available. This also requires a policy level decision to link all the laboratories together either under NCASC or NPHL or both. The challenge is to formulate a comprehensive policy for staffing, training, equipping supplying, monitoring and maintaining the public sector laboratories

Recommendations:

USAID should help facilitate securing other donor resources to make the laboratory network effectively functional, and USAID partners could provide technical support and training of staff.

Activity 5. NGO capacity building strengthened

Major expansion of NGO participation in the national HIV/AIDS effort has advanced significantly, greatly expanding NGOs serving most-at-risk groups, as well as building their capacity for program implementation.

Achievements:

- FHI doubled the number of its NGO partners from 12 in 2002 to 24 in 2004, including an increase in their support for indigenous NGO partners from 9 to 22, and several of the NGOs have grown into well-established organizations implementing multiple HIV/AIDS activities.
- FHI completed capacity-building assessments of 13 implementing agencies (IAs) followed by plan preparation, and conducted cost analyses in 13 BCI projects.
- FHI supported VCT project development for 19 NGOs.
- PSI provided technical and financial support to 22 local NGOs, non-profit groups and private sector organizations to market condoms and for other activities.
- The increase in the number of NGOs strengthening capacity has significantly expanded geographic and service access to most-at-risk groups.
- FHI, PSI and POLICY Project have been providing technical assistance and capacity building support to vulnerable groups and associations (Sneha, NANGAN, NNP+), which is essential to increase the presence of civil society and especially vulnerable groups in HIV/AIDS prevention and care activities.

Challenges:

The escalation of the civil insurgency is clearly presenting a rapidly-growing threat to the local NGOs who have played such an important part in expanding access to and coverage of the most-at-risk groups—and to the ability of FHI and PSI to provide the necessary technical, logistical and managerial support to their local partners. It is likely that the situation may worsen before improving. This issue is one of the primary challenges to continued success in the NGO component of the program. The local pressure from the insurgents has also forced migration

out of affected areas, much of it toward Kathmandu and other urban centers, but also across the border into India. This further complicates the problem of access and coverage.

Recommendations:

Addressed under Social Marketing and Mission Management sections.

Summary:

There has been significant progress in building national and local capacity to implement the national HIV/AIDS program in line with the strategic priorities of USAID's HIV/AIDS Strategy. FHI's doubling capacity building of NGO partners—particularly local NGOs has had an important impact on serving the most-at-risk groups in the key affected geographic areas. The inauguration of the PSI condom social marketing program has further complemented and strengthened NGO programs, and it appears that this increased capacity has equipped the NGO network to reach as much as 40% of the affected groups, except for the IDU group.

Despite frequent changes in MOH and NCASC leadership and technical staff, there have been notable advances in building national government capacity and strengthening policy and program initiatives. The addition of the Policy Project team has opened many opportunities for addressing key policy issues, initiating studies, such as the Legal Audit, which focus government attention on critical policy areas, and the work of FHI in building technical working groups and developing technical guidelines have helped to keep the government engaged.

The second generation surveillance network has not been fully developed, but a series of special studies by FHI have produced needed data to adequately track key aspects of sero prevalence in most-at-risk groups. The ICDDR,B study of laboratory capacity has shown a challenging level of weakness in the majority of existing laboratories which will require substantial investment to serve program needs, especially if ART at any scale becomes a reality.

The impact of the insurgency is a serious impeding force in many aspects of the national HIV/AIDS effort, and the Mission needs to help guide and support the implementing partners to find effective ways to address this problem in its current state and as it may evolve.

USAID's CA partners should continue to choose opportunities to provide support to selected policy and program activities which can maintain government involvement and improve specific technical and policy aspects of the NCASC and foster improved program implementation. In both the government and non-government program activities, USAID's CA partners need to improve coordination and collaboration in planning and implementation more productively to better achieve expected results.

IR 2.3.2 Increased access to information and prevention services for HIV/AIDS and other sexually transmitted infections

USAID has been working on HIV prevention programs in Nepal since 1994 initially in 9 eastern districts along the border with India and later with 16 more including all those along the border. The strategy called for expansion to include three districts in Kathmandu valley, one district in West Nepal (Kaski) and Doti and Bajhang in the Far West, for a total of 29. The strategy

organized this IR along three programmatic areas: behavior change interventions, sexually transmitted infections and social marketing.

Activity 1. Behavior change interventions (BCI)

The BCI program has been implemented by FHI with assistance from PSI and to some extent the POLICY Project. The BCI program includes peer education, establishment of drop in centers, condom promotion, and media support. The program emphasizes the ABC's (Abstinence, Be faithful and correct and consistent Condom use) of HIV prevention in order to reduce risk behaviors. The target populations have been mapped by FHI and their partner implementation organization Center for Research on Environment, Health and Population Activities (CREHPA) to determine coverage of activities by the BCI program. The following table outlines the estimates of target population based on mapping and key informant interviews for FSW and IDUs:

Target Population	Current national estimates
Female Sex Workers	16,650 - 34,300
Injecting Drug Users	16,100 – 28,000
Migrants from Nepal to India	600,000 - 1 million
Men who have sex with men (MSM)	Currently unknown

Source – National Estimates of Adult HIV Infections, Nepal 2003

The goal of the HIV program is for 80% of the targeted most-at-risk target populations in the program area to be provided a comprehensive package of prevention, care and support services.¹ FHI estimates that 40% of the FSW population in the 22 Terai districts, slightly more in Pokhara and about 40% in Kathmandu Valley have been reached. FHI has plans to reach a total of 80% of FSWs in their target areas in the next two years. Behavior change will be reported in the regular BSS reported condom use in high-risk sexual encounters.

The BCI programs with the IDU's were initially conducted through the Nepal Initiative's work with 20 NGOs. Where possible, FHI has incorporated some of these programs in the urban areas without the needle exchange component. The conclusion of the final IDU programs with SC/US in April will leave this important target population without services.

The MSM program is just starting with initial mapping exercises and studies conducted with the assistance of Blue Diamond Society. Sero-studies are planned but not yet conducted. Initial studies have been conducted with the returned migrants from India, but program implementation has not been initiated due to access difficulties in these heavily Maoists areas. Work has started with USAID/India to plan interventions with Nepali migrants in Mumbai.

FHI set up three programs to reach these most-at-risk populations; safe highways, safe cities and safe migration to be implemented by 24 local NGOs.

- Safe Highways – BCI programs have been set up with FSWs and their clients along the east/west highway in 22 districts and between Kathmandu and Pokhara
- Safe Cities – BCI programs in high-risk areas in Kathmandu valley and Pokhara
- Safe Migration – Program activities aimed at the returned migrants from India in districts in the mid and far western regions of Nepal.

¹ USAID/Nepal and Implementing Partner HIV/AIDS Strategies, pg. 13.

The BCI programs were supported by a media campaign, which was handed over to PSI in 2002.

Achievements:

Safe Highways

- All major highways are covered in 24 districts with BCI programs reaching the FSWs along the highway teashops and truck stops.
- Drop-in centers were established for IDUs and FSWs.
- BCI services are linked to STI and social marketing services.
- HIV prevalence has been maintained in the 16 eastern districts with FSW sero prevalence of 3.9% in 1999 and 3% in 2003.
- Last time condom use has increased in both FSWs and their clients from 62% and 76% respectively to 90% and 92%
- Consistent condom use has also increased with FSWs and their clients from 36% and 33% to 80% and 54%.

Safe Cities

- Sero-prevalence for FSWs in Kathmandu has leveled off at 15.7% in 2002 from a high of 17% in 2000.
- IDU and FSW, and trucker drop-in centers were established in high-risk areas within the cities and along the ring road in Kathmandu
- Last condom use is at 90% among FSWs in Kathmandu

Safe Migration

- Some research on migrants has been completed in Achham and Doti which indicated migration to Mumbai to be a risk factor.
- Work has been initiated by USAID and FHI to start programs in Mumbai to reach Nepali migrants.
- FHI is starting to work with the UNDP to develop radio programming to reach migrant families both the Far West in Nepal and Mumbai, India with Nepal language specific HIV prevention messages through the Equal Access program.

Other programs

- PSI expanded the program providing socially marketed condoms to non-traditional outlets to improve access of condoms among most-at-risk populations, particularly the clients of FSWs.

Challenges:

The multi-donor Nepal Initiative implementation, led by the UNDP under the auspices of the NCASC, resulted in a decrease in programs from 20 NGOs implementing IDU BCI and needle exchange programs to 10. The IDU target population, which has the highest HIV prevalence, is no longer being adequately covered. At the same time the returned migrants from Mumbai and their families are difficult to access since they often live in remote villages in mostly conflict torn areas.

Although PSI and FHI have a joint BCI work plan, they are still experiencing some difficulties with coordinating the implementation. However, FHI has recently developed, in collaboration

with its NGO partners, PSI and the NHIECC, a BCI strategy. PSI has just completed data collection for its Omnibus Survey (MROS) which is designed to identify, and then address, factors and impediments to the use of condoms by FSWs. This survey is meant to inform both CAs, and their partners, of how better to deliver BC interventions.

Recommendations:

USAID needs to continue to work closely with the other donors to ensure coverage of target populations in Nepal. The GFATM, should it come about, may support programs aimed at IDUs pending resolution of financial management issues with the government. The returned migrants from Mumbai need to be reached through alternative approaches as the conflict makes access to many of the source areas for migration difficult.

USAID needs to take a stronger role in coordinating FHI and PSI to ensure optimal usage of funds to reach the population. For example, PSI's plans to target FSWs with behavior change interventions needs to be closely coordinated with FHI for synergies.

The inclusion of PLWHA in all BCI activities is vital for BCI programming as are efforts to scale up activities with MSM and the more vulnerable street based sex workers.

Activity 2. Sexually transmitted infections

The 1999 BSS-HIV/AIDS/STI sero study found syphilis to be a serious risk factor for HIV transmission in Nepal. Truckers with untreated syphilis were ten times more likely to be infected with an HIV infection. 19% of FSWs in the Eastern Terai had untreated syphilis. FHI is the main implementer of the STI program, and PSI plans to market a pre-packaged therapy for urethral discharge in men this year.

Accomplishments:

- 27 districts were covered with STI services through Nepal Family Care Center (NFCC) and Asia Medical Doctors Association (AMDA) NGOs.
- 19 districts included lab support in 12 static clinics and 25 mobile clinics were conducted each month serving over 16,000 people.
- 129 private practitioners were trained to provide syndromic treatment of STIs in 8 districts without access to laboratory services.
- Syphilis decreased from 1999 to 2003. FSWs had 18.8% untreated syphilis in 1999 and 9.5% in 2003, truckers had 5.3% untreated syphilis in 1999 and 4.5% in 2003.
- JICA has agreed to provide STI drugs (and HIV test kits) for the FHI supported STI clinics for the next 5 years.
- The Narayani Transport Entrepreneurs Association is working with FHI to provide a static STI clinic for truckers in Hetauda.

Challenges:

There does not seem to be a standard fee schedule for services (drugs are free) at the FHI-supported clinics. NFCC originally bulk ordered STI drugs and was able to charge half of the pharmacy prices. AMDA has a sliding scale for drug prices as well. The introduction of the JICA STI drugs will be another factor to consider in this pricing structure. Local JICA authorities have informed USAID that the issue of pricing of the drugs they have provided needs to be discussed at the highest levels of the organization in Japan. This may take sometime to

resolve. There are no laboratory services in 8 districts and the syndromic approach does not work well with Nepali women.

Recommendations:

STI services can be strengthened through establishing a standard price structure for STI drugs as the free JICA drugs are brought into the program to ensure sustainability. USAID, JICA and FHI will have to work together to set up this pricing structure at all USAID-supported locations where STI services and drugs will be available. Laboratory services should be included in the 8 Western districts if at all feasible.

USAID needs to coordinate the implementation partners to ensure maximum impact of the STI programs and maximum usage of the pre-packaged therapy for the clients of sex workers. Partners need to include STI services as part of the prevention to care continuum and must include PLWHA as part of that process.

Activity 3. Social Marketing

The social marketing program in Nepal was originally set up by USAID along with Contraceptive Retail Sales (CRS). CRS began operations in 1978 as a pilot under HMG's (His Majesty's Government) FP/MCH Project of the Ministry of Health. In 1983, CRS acquired corporate stature and became a non-profit private limited company. The Mission found that CRS was only distributing contraceptives and did not have sufficient expertise and experience to conduct a social marketing program. In order to address this problem effectively the Mission brought in Population Services International (PSI) to implement activities in support of HMG's efforts for the prevention and control of HIV and STD infections and the promotion of family planning and maternal child health in Nepal through advocacy, behavior change communication, and developing private sector markets for health products.

Achievements:

- A new condom *Number One*, targeted at youth was launched in April 2003 and in less than one year has sold nearly 7 million condoms.
- A successful branded Number One media campaign was launched and is very visible throughout Nepal through billboards, danglers and other promotional activities.
- Total condom sales increased from 11 million in 2002 to over 16 million in 2003, growing the market by 41% in one year.
- Non-traditional outlets servicing areas of most-at-risk sexually behavior has increased to over 14, 000 outlets.
- PSI is taking the lead along with FHI and POLICY to map out through GIS technology, areas of most-at-risk sexually behavior to determine where traditional and non –traditional outlets should be established.
- PSI and FHI collaborated on a successful Black and White HIV campaign.

Challenges:

Planning non-traditional outlets placement is not sufficiently coordinated with the BCI programs of FHI. The sharply increased demand for condoms resulting from the success of the social marketing program and production problems with the condom manufacturer has put a strain on condom supplies. Due to the manufacturer's production problems AID/Washington has not

been able to supply condoms to Nepal as per their needs. This has led to temporary shortage of condoms in Nepal. With the increase in demand for condoms continuing for a foreseeable future there may be significant shortage of condoms if sufficient funds are not available to meet the rising demand for condoms in Nepal.

Recommendations:

Two assessments -- Media Recall Study of the Second Generation HIV/AIDS/STI Prevention and Control Media Campaign and Evaluation of the Celebrity Multi-Media Campaign for HIV/AIDS Prevention – were completed under the Nepal Initiative. One media campaign (Black & White) is still active and will be assessed once completed by the Mission to determine the need for another media campaign for the general population, bearing in mind that the epidemic in Nepal is concentrated among most-at-risk groups. This activity will complement the continual coordination of the implementing partners. The GIS mapping of high-risk areas is very exciting and could provide solutions to coordinating the targeting of outlets and BCI programs and should be supported.

The Mission needs to work with other donors to request their financial assistance with condom the burden of buying condoms social marketing. Longer term sustainability of the condom supply in face of continued demand increase needs to be addressed.

Summary:

Excellent progress has been achieved in this IR for expanding and improving information and preventive services. The BCI activities in the strategy are on target with approximately 40% of FSWs in target areas being reached, nearly 7 million condoms sold, over 16,000 STI clients served and use of condoms at the last sex act remains high among FSWs and their clients. Improved coordination among the implementing partners will result in even greater success.

The Mission needs to stress the inclusion of PLWHA in all activities and concentrate on scaling up activities aimed at MSM and returned migrants. Given the decline of the Nepal Initiative, the Mission needs to engage donors in supporting an ongoing IDU BCI and needle exchange program.

IR 2.3.3 Increased access to care and support

Despite the fact that Nepal is a low prevalence country, the strategy recognized that efforts were needed to address care and support services for persons affected by HIV/AIDS. This was in line with USAID's revamped HIV/AIDS policy which called for providing a comprehensive continuum of services. To achieve results under this S-IR, the following activities were proposed:

- Voluntary Counseling and Testing (VCT) programs established and expanded
- Community programs strengthened to provide care and support for those affected by HIV/AIDS, including vulnerable communities
- Capacity to provide medical and psychological care strengthened
- Mother to Child Transmission (MTCT) programs established

Activity 1. Voluntary Counseling and Testing (VCT) programs established and expanded

The VCT component of the strategy addresses the need to meet the demand from those who want to know their HIV status and link those persons, particularly members of most at-risk populations, to effective prevention and care and support services.

In 2002, Nepal had one VCT site that met the WHO protocol². This site had been operational for some time, but was severely underutilized. There were no coordinated efforts to scale-up VCT on a national scale; pre-requisites for effective VCT efforts, such as guidelines and curriculum, were non-existent.

Achievements:

- USAID, through FHI, helped to establish a VCT, Care and Support Technical Working Group whose purpose was to assist the NCSAC in the design, coordination, management and implementation of national VCT activities. The working group helped to develop and publish National VCT guidelines and finalize a national VCT training curriculum.
- Currently, there are 5 VCT sites which meet national standards. Mechanisms are in place to have up to 10 sites operating by the end of the year. While the 2003 targets for the number of VCT sites established were not met, this should not be a major concern since efforts are in line to meet the overall targets for the relevant indicator within the 5-year plan.
- The establishment of the two newest VCT sites at locations which serve IDU and sex workers reflects a well thought out VCT roll-out strategy. Both sites have appointments booked for several weeks and are completing the training of additional counselors to meet the demand for counseling and testing.
- The quality of the VCT guidelines is evident by the use of a rapid testing algorithm that enables individuals to receive their results immediately and thereby addresses the loss to follow-up when people have to return at a later date for their test results.

Challenges:

While the quality of the VCT site services is reflected in the limit on the number of persons scheduled per day to ensure sufficient time with clients in case of positive test results, demand for VCT services has created a long waiting list which needs to be resolved by completing the training of additional counselors. Space and manpower limitations currently limit the number of counseling sessions to five per day.

Activity 2. Community programs strengthened to provide care and support for those affected by HIV/AIDS, including vulnerable communities

Accomplishments in strengthening community programs to provide care and support to those affected by HIV appear to be more limited.

Achievements:

- A pilot program was undertaken by Save the Children/US in Kanchanpur district, the “HIV/AIDS Impact Mitigation through Mobilizing Affected Communities” project. This pilot, aimed at developing a platform on which to build community support, was undertaken in

² CF. Trip Report by Joan MacNeil, Sr. Technical Officer, ARO, FHI, dated April 27, 2002, pg. 2.

June 2001, at a time when options for clinical care in Nepal, and ARVs in particular, were limited. The project, which ended in June 2003, focused on awareness raising to increase community capacity to provide care and support to PLWHA and their families, and provided some lessons learned regarding the level of effort required to make the health care system amenable to caring for HIV/AIDS patients.

Challenges:

There does not appear to have been much follow-up in terms of either utilizing the results/lessons learned from the pilot or planning for scaling-up community-based care and support activities. This is a problem, particularly in light of the need to integrate clinical care into community and home-based care activities.

Most of the effort under this activity - the proposed formation of post-test clubs, the assessments and development of resource directories, and referrals through case management, while important, are limited in their impact on strengthening community programs and miss the need to address the integration with clinical care.

Recommendations:

Greater emphasis needs to be placed on community programs. The Mission should work with the CA to scale-up integrated community and home-based care programs. These programs should address the continuum of care for PLWHA and their families from VCT through to palliative care.

Activity 3: Capacity to provide medical and psychological care strengthened

The lack of emphasis on strengthening community care and support programs also affects, to some extent, the strengthening of capacity to provide medical and psychosocial care. This activity was designed (appropriately, at the time that the strategy was developed) to focus on supporting systems improvement through pre- and in-service training of health care personnel, national guidelines development, drug delivery and improving quality of care.

Achievements:

- There have been some achievements under this activity, notably in the technical assistance to the NCASC in the development of national ARV guidelines and ARV site guidelines and administrative procedures at Sukra Raj Hospital in Kathmandu.

Challenges:

While it is important to work on procedural issues related to clinical care and to strengthen the government's capacity in this area, some decisions need to be made regarding where to best focus future efforts in relation to this activity.

The government ARV program is still weak; after opening their ARV program, it has not been able to fill the first 25 patient slots. There is some question as to how beneficial centralized efforts will ultimately be in terms of clinical care to the greatest number of PLWHA.

Recommendations:

A rethinking of this activity based on how and where PLWHA are receiving medical and psychological care is in order.

In addition, efforts should be made to insure that PLWHA are more actively involved in determining how medical and psychosocial services should be planned and delivered.

Activity 4. Mother to Child Transmission (MTCT) programs established

MTCT program establishment was included in the strategy based on Agency policy considerations at the time of strategy development. USAID's emphasis on MTCT focused on providing TA to the government in the development of a national MTCT learning site.

Challenges:

Low HIV prevalence rate among pregnant women and the low number of institutional births, weak efforts by the government and difficulties experienced by UNICEF in getting an appropriate technical person for MTCT have limited implementation of MTCT activities in Nepal.

Recommendations:

This activity was not scheduled to take place until the second and third years of the strategy. USAID's current level of effort on this activity is appropriate and no additional efforts need to be considered at this time.

Summary:

Accomplishments and direction of activities under this S-IR are mixed. In the area of VCT, results have been exemplary. In other areas such as community based support, more consideration needs to be given to integrating clinical components (OI prophylaxis and treatment, ARV provision, palliative care) and psychosocial support (PLWHA support groups, counseling) into the continuum of services for PLWHA and other vulnerable groups.

Addressing these activities is particularly difficult because of a) the rapidly changing global picture related to clinical care and ARVs, b) shift in USG emphasis on providing care and treatment, and c) the need to balance support for government institutions with community-based clinical and supportive care in the current environment. Implementation of activities related to this S-IR lacks a comprehensive approach to care and support and (with the exception of VCT capacity development and implementation) appears to follow a compartmentalized planning process. Funding for these activities is approximately 11% of the budget, which, while appropriate at the time that the strategy was designed, should be revisited.

More attention needs to be given to how activities are implemented. Greater coordination between FHI and the Mission on technical planning that reflects both USG priorities and the changing practices in the field of care and support should be undertaken. The Mission should also revisit some of the targets in the care and support indicators since these were originally chosen based upon assumptions operating earlier, and may now be considered low in relation to funding levels.

IV. Review of Indicators

Indicators Proposed in the Strategy

Strategic Objective 2: Reduced Fertility and Protected Health of Nepalese Families

IR 2.3: Increased use of HIV/AIDS prevention and care services by the most-at-risk groups (FSW, IDU, MSM, migrant males)

- 2.3.0 Percent HIV positive among female sex workers (FSW)
- 2.3.1 Surveillance conducted according to international standards
- 2.3.2 AIDS Program Index
- 2.3.3. Number of USAID-assisted indigenous NGOs providing HIV/AIDS services
- 2.3.4 Measurement of stigma reduction – indicator to be determined
- 2.3.5 Condom use
 - a Use at last risky sex
 - b Consistent use
- 2.3.6 Total condom sales
- 2.3.7 Total condom sales to most-at-risk groups
- 2.3.8 Number of USAID-assisted sites providing sexually transmitted infection treatment
- 2.3.9 Number of most-at-risk individuals receiving sexually transmitted infection treatment
- 2.3.10 Percentage of men in most-at-risk male sub population groups who report sex with FSW in the last 12 months
- 2.3.11 Voluntary HIV counseling and testing sites established according to national standards
- 2.3.12 Number of clients seen at voluntary counseling and testing sites
- 2.3.13 Number of people living with HIV/AIDS reached with basic care and support services in USAID-targeted areas

Technical review of the Performance Monitoring Plan indicators was conducted with the Mission and USAID partners. Overall, the monitoring and evaluation plan for collecting performance indicators is on track. Certain indicators required technical assistance and guidance. These are discussed below.

Seroprevalence of FSW

Current methods for collecting data on HIV prevalence among female sex workers has been done in Kathmandu, 16 Eastern Terai districts and 6 Western Terai districts are being conducted. A discussion of moving toward national tracking of FSW in the future ensued, however the current plan is to continue tracking the target areas already covered in order to measure progress over time. There is a plan to compare the Eastern and Western Terai samples and possibly combine these into one sample for future studies.

Additionally, national surveillance, which currently plans to collect samples from 9 STI sites is very weak. One idea was to work with the Nepal Red Cross, which has 1,343 blood collection sites in 40 districts that collected more than 73,000 pints of blood between June 2002 and May 2003 and reported an HIV prevalence of 0.44% to ensure technical quality and use this data for national surveillance estimates.

Stigma/Discrimination

The development of stigma and discrimination indicators that measure program progress over time has been difficult. In Washington, a Technical Working Group has been working on this issue and is piloting several methods for data collection and the pilot questions were discussed

and there was great interest expressed in utilizing training on the stigma/discrimination "toolkit" and the pilot monitoring and evaluation methods in the future.

The current activities of the Mission focus primarily on policy review and improvement and training and sensitization of key professionals, such as health care workers and other program staff. Thus, 2 indicators were proposed:

- Number of persons trained/sensitized for stigma/discrimination reduction (program reports, disaggregated by health care workers vs. other community members);
- Improved national policies which respect the rights of PLWHA and reduce stigma/discrimination (assessment/ document review).

Condom Sales and use

A cable from Washington stated that 'Total condom sales was no longer to be used as a performance measure. Rather condom use and sales from non-traditional outlets were to be used. As per this guidance, Total condom sales was dropped from the PMP. Condom use is already represented including use at last risky sex and consistent condom use in risky sex. The indicator for total condom sales to most-at-risk groups was discussed. Measuring sales to hidden and hard-to-reach risk groups, such as IDUs and MSM, was found to be unfeasible and was changed to: Total condom sales in non-traditional outlets. Non-traditional outlets is normally thought of as any outlet besides pharmacy or health center/clinic. But in concentrated epidemic centers, traditional outlets may actually serve high risk groups if they are located in targeted locations. Thus, "non-traditional" outlets for the indicator will be defined as service outlets which are in the geographic proximity (measured by both travel time and distance) to high risk settings and those specifically marketed to high risk groups. Innovative GIS tracking of outlets is currently being developed by PSI that will further refine and validate the targeting of these outlets.

As mentioned above, condom use data among FSW and male sub-populations that have been shown by studies to typically frequent them (truckers, laborers) are being collected. The additional indicator --Percentage of men in most-at-risk male sub population groups who report sex with FSW in the last 12 months was thought to be unhelpful for programs. The UNGASS indicator was suggested. This indicator-- Percent of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission was adapted to Nepal's strategy for high risk groups. Thus, the proposed new indicator was developed--Percent of high risk populations who both correctly identify ways of preventing the sexual transmission of HIV (including A, B, C) and who reject major misconceptions about HIV transmission.

Care and Support

The key indicators, (number of VCT sites, number of VCT clients, and number of people living with HIV/AIDS reached with basic care and support services in USAID-targeted areas) were discussed and definitions were matched with the current PEPFAR definitions (sites = service outlets). Targets in this area were increased considerably.

PEPFAR Strategic Information Planning

The indicators and program level matrix for PEPFAR were shared with the Mission and partners who are reviewing these as a precursor for the time when monitoring of PEPFAR goes beyond

the 14/15 countries into concentrated epidemics. Generally, the program level matrix is relevant while many of the national population indicators would need to be targeted to high risk groups in order to serve the needs of Nepal.

V. Conclusions

Technical Summary

IR 3.2.1 Increased national capacity to provide HIV/AIDS services

There has been significant progress in building national and local capacity to implement the national HIV/AIDS program in line with the strategic priorities of USAID's HIV/AIDS Strategy. FHI's doubling and building capacity of the NGO partners—particularly local NGOs has had an important impact on serving the most-at-risk groups in the key affected geographic areas. The inauguration of the PSI condom social marketing program has further complemented and strengthened the NGO programs, and it appears that this increased capacity has equipped the NGO network to reach as much as 40% of the affected groups, except for the IDU group.

Despite frequent changes in MOH and NCASC leadership and technical staff, there have been notable advances in building national government capacity and strengthening policy and program initiatives. The addition of the POLICY Project team has opened many opportunities for addressing key policy issues, initiating studies, such as the Legal Audit, which focus government attention on critical policy areas, and the work of FHI in building technical working groups and developing technical guidelines have helped to keep the government engaged.

The second generation surveillance network has not been fully developed, but a series of special studies by FHI have produced needed data to adequately track key aspects of sero prevalence in most-at-risk groups. The ICDDRDB study of laboratory capacity has shown a challenging level of weakness in the majority of existing laboratories which will require substantial investment to serve program needs, especially if ART at any scale becomes a reality.

IR 3.2.2 Increased access to information and prevention services for HIV/AIDS and other sexually transmitted infections

Excellent progress has been achieved in this IR for expanding and improving information and preventive services. The BCI activities in the strategy are on target with 40% of FSWs being reached in FHI program areas, 15.2 million total condoms sold (all brands), over 16,000 STI clients served and last condom use remaining high. Improved coordination among the implementing partners will result in even greater success.

The Mission needs to stress the inclusion of PLWHA in all activities and concentrate on scaling up activities aimed at the MSM and returned migrants. Given the decline of the Nepal Initiative, the Mission needs to engage donors in supporting an ongoing IDU BCI and needle exchange program.

The impact of the Maoist insurgency is a serious impeding force in many aspects of the national HIV/AIDS effort, and the Mission needs to help guide and support the implementing partners to find effective ways to address this problem in its current state and as it may evolve.

USAID's CA partners should continue to choose opportunities to provide support to selected policy and program activities which can maintain government involvement and improve specific technical and policy aspects of the NCASC and foster improved program implementation. In both the government and non-government program activities, USAID's CA partners need to improve coordination and collaboration in planning and implementation more productively to better achieve expected results.

IR 3.2.3 Increased access to care and support

Accomplishments and direction of activities under this S-IR are mixed. In the area of VCT, results have been exemplary. In other areas such as community based support, more consideration needs to be given to integrating clinical components (OI prophylaxis and treatment, ARV provision, palliative care) and psychosocial support (PLWHA support groups, counseling) into the continuum of services for PLWHA and other vulnerable groups.

Addressing these activities is particularly difficult because of a) the rapidly changing global picture related to clinical care and ARVs, b) shift in USG emphasis on providing care and treatment, and c) the need to balance support for government institutions with community-based clinical and supportive care in the current environment. Implementation of activities related to this S-IR lacks a comprehensive approach to care and support and (with the exception of VCT capacity development and implementation) appears to follow a compartmentalized planning process. Funding for these activities is approximately 11% of the budget, which, while appropriate at the time that the strategy was designed, should be revisited.

More attention needs to be given to how activities are implemented. Greater coordination between FHI and the Mission on technical planning that reflects both USG priorities and the changing practices in the field of care and support should be undertaken. The Mission should also revisit some of the targets in the care and support indicators since these were originally chosen based upon assumptions operating earlier, and may now be considered low in relation to funding levels.

